# Wu Siew Yong v Pulau Pinang Clinic Sdn Bhd & Anor

HIGH COURT (PULAU PINANG) — CIVIL SUIT NO 22–42 OF 2003
CHEW SOO HO JC
25 AUGUST 2010

*Professions — Medical practitioners — Negligence — Duty of care — Duty to use skill, knowledge, diligence and care in administering treatment — Whether doctor negligent in conduct of laparoscopy — Whether doctor breached duty of care in declining to carry out open surgery — Whether danger to patient's safety outweighed necessity to perform investigatory operation — Whether doctor acted wrongfully in administering Zoladex injections on plaintiff — Whether breach of duty established*

*Professions — Medical practitioners — Negligence — Vicarious liability — Liability of private hospital for negligence of doctor — Whether employer-employee relationship existed — Negligent act complained of was personal act of doctor in treatment, management and care of patient — Doctor retained full control over patient — Whether private hospital vicariously liable*

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The plaintiff consulted the second defendant on 21 May 2001 with the history and complaint of pain in the abdomen before menstruation and dysmenorrhoea, inter alia. The second defendant was an obstetrician and gynaecologist practising at the Gleneagles Medical Centre ('the hospital'), wholly owned and operated by the first defendant. Through an ultra sound scan, the plaintiff was diagnosed clinically to have endometriotic cyst in her left and right ovary. She was admitted to the hospital on 5 June 2001 for surgical

procedure called laparoscopic ovarian cystectomy. On 6 June 2001, second defendant performed the laparoscopy on the plaintiff to confirm the presence of the two endometriotic cysts and forthwith to remove them. After the laparoscopy, however, no cyst was seen and cystectomy was thus not carried out. The plaintiff was then given injection of Zoladex. However, despite the laparoscopy having been done, the plaintiff still suffer the same complaint of pain. She subsequently visited the Sungai Petani Hospital where after scanning, the plaintiff suspected that she still had the cysts which second defendant did not remove. On 8 July 2002, Dr Benny Khaw from Singapore Women's Specialist Centre had successfully removed the plaintiff's two endometriotic cysts and she did not suffer the same complaint since then. The plaintiff alleged that the second defendant had breached his duty of care to the plaintiff in failing to remove the endometriotic cysts in her left and right ovary during the laparoscopy performed on 6 June 2001 and had wrongfully administered two Zoladex injections on her. She filed this action for damages alleging professional negligence on the part of the second defendant. The second defendant contended that no endometriotic cysts seen during the laparoscopy conducted on 6 June 2001 on the plaintiff and the two Zoladex injections given to the plaintiff were an accepted form of treatment for the endometriosis that the plaintiff was suffering from. The issues arising for determination were: (i) whether the plaintiff had two endometriotic cysts before and at the time the laparoscopy was performed by second defendant on 6 June 2001; (ii) whether second defendant was negligent in the course of performing the laparoscopy; (iii) whether it was wrongful for second defendant to administer two Zoladex injections on the plaintiff after laparoscopy; and (iv) whether the first defendant was vicariously liable for the second defendant's acts.

**Held**, dismissing the plaintiff's claim with costs:

(1) The plaintiff failed to prove the presence of the two endometriotic cysts before and at the time the second defendant performed the laparoscopy on her. There was no endometriotic cysts bearing in mind that the actual confirmation of the presence of endometriotic cysts is by laparoscopy and not by ultrasound scan. All the plaintiff's witnesses endorsed that an ultrasound scan is not conclusive without a laparoscopy. Ultrasound is not conclusive proof to ascertain the presence or existence of cysts and hence the plaintiff could not base her case on mere ultrasound finding (see paras 12–13).

(2) There was no medical or expert evidence adduced by the plaintiff to prove the negligence of the second defendant in the conduct of the laparoscopy. Thus, the court could not draw any inference as to any negligence on the second defendant in the conduct of the laparoscopy (see para 14).

(3) The doctor owes a duty to the patient to use his skill, knowledge, diligence and care in administering treatment. There was no evidence that the second defendant had breached his duty of care to the plaintiff in the management and treatment of the plaintiff or that second defendant had been negligent in conducting the laparoscopy to ascertain the presence of endometriotic cysts before the laparoscopic ovarian cystectomy could be performed to remove them. The second defendant also did not breach his duty of care when he declined to carry out open surgery as he had balanced the risk and benefit of such open surgery to the plaintiff. He had exercised due diligence, care, skill and knowledge in circumstances where the danger to the patient's safety outweighed the necessity to perform an investigatory operation (see para 17).

(4) The administering of Zoladex injections on the plaintiff was after consultation with the plaintiff and it was administered with her full consent. From the evidence, there was no doubt that Zoladex injections are the recognised and accepted medication for the treatment of endometriosis. The plaintiff has had a history of endometriosis and her complaints indicated the recurrence of endometriosis. Hence, the second defendant had not acted wrongfully in administering Zoladex injections on the plaintiff (see paras 19–20).

(5) There was no employer-employee relationship between the first and second defendants. The negligent act and wrongful act complained of by the plaintiff was in relation to the personal acts of the second defendant in the treatment, management and care of the plaintiff which the second defendant retained full control. Therefore, the first defendant could not be said to be vicariously liable (see paras 21 & 22(f)).

**[Bahasa Malaysia summary**

Plaintif telah meminta nasihat defendan kedua pada 21 Mei 2001 dengan sejarah dan aduan sakit di bahagian abdomen sebelum haid dan dismenoria, antara lain. Defendan kedua merupakan pakar obstetrik dan pakar ginekologi yang beramal di Pusat Rawatan Gleneagles ('hospital tersebut'), yang dimiliki sepenuhnya dan dijalankan oleh defendan pertama. Melalui satu imbasan bunyi ultra, plaintif telah didiagnos secara klinikal mempunyai sista endometriotik di bahagian kira dan kanan ovarinya. Dia telah dimasukkan ke hospital pada 5 Jun 2001 untuk prosedur pembedahan dikenali sebagai sistektomi ovari laparoskopik. Pada 6 Jun 2001, defendan kedua telah melaksanakan laparoskopi ke atas plaintif untuk mengesahkan kehadian dua sista endometriotik dan seterusnya membuangnya. Walau bagaimanapun, selepas laparoskopi itu, tiada sista ditemui dan sistektomi tidak dilaksanakan. Plaintif kemudian telah diberikan suntikan Zoldex. Namun begitu, meskipun laparoskopi itu telah dibuat, plaintif masih mengalami sakit tersebut. Dia kemudian telah pergi ke Hospital Sungai Petani di mana setelah membuat imbasan, plaintif mensyaki dia masih mempunyai sista yang mana defendan

kedua tidak buang. Pada 8 Julai 2002, Dr Benny Khaw dari Pusat Pakar Wanita Singapura telah berjaya membuang dua sista endometrotik plaintif dan dia tidak lagi mengadu sakit sejak itu. Plaintif mendakwa bahawa defendan kedua telah melanggar kewajipan berjaga-jaganya kepada plaintif kerana gagal membuang sista endometriotik di ovari kiri dan kanannya semasa laparoskopi dilaksanakan pada 6 Jun 2001 dan telah dengan salah melakukan dua suntikan Zoladex ke atasnya. Dia telah memfailkan tindakan ini untuk ganti rugi dengan mendakwa kecuaian professional di pihak defendan kedua. Defendan kedua menegaskan bahawa tiada sista endometriotik dikesan semasa laparoskopi dilakukan pada 6 Jun 2001 ke atas plaintif dan dua suntikan Zoladex yang diberikan kepada plaintif merupakan rawatan yang diterima untuk endometriosis yang dialami oleh plaintif. Isu-isu berbangkit untuk ditentukan adalah: (i) sama ada plaintif mempunyai dua sista endometriotik sebelum dan pada masa laparoskopi dilaksanakan oleh defendan kedua pada 6 Jun 2001; (ii) sama ada defendan kedua cuai dalam melaksanakan laparoskopi itu; (iii) sama ada salah untuk defendan kedua melakukan dua suntikan Zoladex ke atas plaintif selepas laparoskopi itu; dan (iv) sama ada defendan pertama bertanggungjawab secara vikarius untuk tindakan defendan kedua.

**Diputuskan**, menolak tuntutan plaintif dengan kos:

(1) Plaintif telah gagal membuktikan kehadiran dua sista endometriotik sebelum dan pada masa defendan kedua melakukan laparoskopi ke atasnya. Tiada sista endometriotik dengan mengambi kira bahawa pengesahan sebenar kehadiran sista endometriotik adalah melalui laparoskopi dan bukan imbasan bunyi ultra. Kesemua saksi plaintif bersetuju bahawa imbasan bunyi ultra tidak konklusif tanpa laparoskopi. Bunyi ultra bukan bukti konklusif untuk memastikan kehadiran atau kewujudan sista dan justeru itu plaintif tidak boleh menjadikan asas kesnya atas penemuan bunyi ultra sahaja (lihat perenggan 12–13).

(2) Tiada keterangan perubatan atau pakar dikemukakan oleh plaintif untuk membuktikan kecuaian defendan kedua dalam melaksanakan laparoskopi itu. Oleh itu, mahkamah tidak boleh membuat apa-apa inferens berkaitan apa-apa kecuaian ke atas defendan kedua dalam melakukan laparoskopi tersebut (lihat perenggan 14).

(3) Doktor mempunyai kewajipan kepada pesakit untuk menggunakan kemahiran, pengetahuan, ketekunan dan sikap berjaga-jaga dalam melakukan rawatan. Tiada keterangan bahawa defendan kedua telah melanggar kewajipan berjaga-jaganya kepada plaintif dalam menguruskan dan merawat plaintif atau bahawa defendan kedua telah cuai melakukan laparoskopi itu untuk memastikan kehadiran sista endotriotik sebelum sistektomi ovari laparoskopik boleh dilaksankan untuk membuangnya. Defendan kedua juga tidak melanggar kewajipan

berjaga-jaganya apabila dia enggan melakukan pembedahan terbuka kerana dia telah mengimbangi risiko dan manfaat pembedahan terbuka sedemikian ke atas plaintif. Dia telah melakukan ketekunan wajar, sikap berjaga-jaga, kemahiran dan pengetahuan dalam keadaan di mana bahaya kepada keselamatan pesakit melampaui keperluan melakukan pembedahan bertujuan menyiasat (lihat perenggan 17).

(4) Perlakuan suntikan Zoladex ke atas plaintif adalah selepas konsultasi dengan plaintif dan ia telah dilakukan dengan persetujuannya. Berdasarkan keterangan, tidak diragui bahawa suntikan Zoladex itu merupakan rawatan untuk endometriosis yang dikenali dan diterima. Plaintif mempunyai sejarah endmetriosis dan aduannya menunjukkan pengulangan endometriosis. Justeru itu, defendan kedua tidak bertindak secara salah melakukan suntikan Zoladex itu ke atas plaintif (lihat perenggan 19–20).

(5) Tiada hubungan majikan-pekerja antara defendan-defendan pertama dan kedua. Tindakan cuai dan tindakan salah yang diadukan oleh plaintif adlaah berkenaan tindakan peribadi defendan kedua dalam merawat, pengurus dan menjaga plaintif yang mana defendan kedua mempunyai kawalan penuh. Oleh itu, defendan pertama tidak boleh dikatakan bertanggungjawab secara vikarius (lihat perenggan 21 & 22(f)).]

**Notes**

For cases on duty of care, see 12 *Mallal's Digest* (4th Ed, 2005 Reissue) paras 963–1011.

For cases on negligence, see 10 *Mallal's Digest* (4th Ed, 2011 Reissue) paras 1770–1786.

For cases on vicarious liability, see 12 *Mallal's Digest* (4th Ed, 2005 Reissue) paras 1536–1537.

**Cases referred to**

*Chien Tham Kong v Excellent Strategy Sdn Bhd & Ors* [2009] 7 MLJ 261, HC (refd)

*Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593, FC (refd)

*Mathew Scott Oakley & Ors v Dr George Varughese & Anor* [2010] 10 CLJ 322; [2009] 1 LNS 1474, HC (refd)

*Payremalu a/l Veerappan v Dr Amarjeet Kaur & Ors* [2001] 3 MLJ 725, HC (refd)

*Tan Eng Siew & Anor v Dr Jagjit Singh Sidhu & Anor* [2006] 1 MLJ 57, HC (folld)

*Lim Boo Chang (Lim Boo Chang & Co) for the plaintiff.*
*Harjit Singh (Lawrence Pereira & Partners) for the first defendant.*
*JJ Chan (Shearn Delamore & Co) for the second defendant.*

**Chew Soo Hoo JC:**

**[1]** The plaintiff consulted the second defendant on 21 May 2001 with the history and complaint of pain in the abdomen before menstruation and dysmenorrhoea, inter alia, the second defendant is an obstetrician and gynaecologist practising at the Gleneagles Medical Centre ('the hospital'), wholly owned and operated by the first defendant. Through an ultra sound scan, the plaintiff was diagnosed clinically to have endometriotic cyst in her left and right ovary. She was admitted to the hospital on 5 June 2001 for surgical procedure called laparoscopic ovarian cystectomy. On 6 June 2001, the second defendant performed the laparoscopy on the plaintiff to confirm the presence of the two endometriotic cysts and forthwith to remove them. After the laparoscopy, however, no cyst was seen and cystectomy was thus not carried out. The plaintiff was then given injection of Zoladex. However, despite the laparoscopy having been done, the plaintiff still suffer the same complaint of pain. She subsequently visited the Sungai Petani Hospital where after scanning, the plaintiff suspected that she still had the cysts which second defendant did not remove. On 8 July 2002, Dr Benny Khaw from Singapore Women's Specialist Centre had successfully removed the plaintiff's two endometriotic cysts and she did not suffer the same complaint since then. The plaintiff alleged that the second defendant had breached his duty of care to the plaintiff in failing to remove the endometriotic cysts in her left and right ovary during the laparoscopy performed on 6 June 2001 and had wrongfully administered two Zoladex injections on the plaintiff on 7 June 2001 and 5 July 2001. She filed this action for damages alleging professional negligence on the part of the second defendant. The first defendant is sued for vicariously liable since it was its hospital that the second defendant performed the laparoscopy procedure. The second defendant denied all allegations of negligence and contended that there were no endometriotic cysts seen during the laparoscopy conducted on 6 June 2001 on the plaintiff and the two Zoladex injections given to the plaintiff are an accepted form of treatment for the endometriosis that the plaintiff was suffering from.

THE ISSUES

**[2]** The main complaints of the plaintiff herein this case are the failure of the second defendant to successfully remove the two endometriotic cysts in her ovary and the wrongful administering of two Zoladex injections on her. Hence the issues can be deduced as follows:

(a) whether the plaintiff had in actual fact two endometriotic cysts in her ovary before and at the time laparoscopy was performed by the second defendant on 6 June 2001;

(b) whether the second defendant was negligent in the course of performing the laparoscopy;

(c) is it wrongful for the second defendant to administer two Zoladex injections on the plaintiff after laparoscopy; and

(d) is the first defendant vicariously liable for the act of the second defendant.

EVALUATION AND FINDINGS

**[3]** Learned counsel for the second defendant has submitted the cases of *Chien Tham Kong v Excellent Strategy Sdn Bhd & Ors* [2009] 7 MLJ 261, *Mathew Scott Oakley & Ors v Dr George Varughese & Anor* [2010] 10 CLJ 322; [2009] 1 LNS 1474 and *Payremalu a/l Veerappan v Dr Amarjeet Kaur & Ors* [2001] 3 MLJ 725 pertaining to the plaintiff's burden to prove negligence against the defendants on the basis that what was done was what a reasonably competent practitioner skilled in that particular art would not have done or would have done and that the negligence, if proved, would result in damages to the plaintiff; it is not for the defendants to disprove the allegations of negligence contained in the statement of claim. I find the law is trite in relation to the burden and standard of proof. There is no doubt about that and it does not need reiteration.

FIRST ISSUE: WHETHER THE PLAINTIFF HAD IN ACTUAL FACT TWO ENDOMETRIOTIC CYSTS IN HER OVARY BEFORE AND AT THE TIME LAPAROSCOPY WAS PERFORMED BY THE SECOND DEFENDANT ON HER ON 6 JUNE 2001

**[4]** From the facts of the case, it is undisputed that the plaintiff had a history of endometriosis dated back to October 1999 when she consulted Dr Benny Khaw ('PW2') from Singapore Women's Specialist Centre and in December 1999, she had undergone a bilateral cystectomy performed by Dr Kunasegaran ('PW3') of Sungai Petani Hospital to remove an endometriotic cyst in her left ovary and an endometriotic cyst in her right ovary. Endometriosis is a gynaecological condition where the cells similar to the lining of the uterus appears outside the uterine cavity most commonly on the ovaries. It can occur with or without the formation of endometriotic cysts, also known as endometrioma and endometriosis will occasion the symptoms of pelvic pain, painful menstruation, painful sexual intercourse and infertility.

**[5]** Evidence of the plaintiff ('PW1') showed the chronological events that took place as follows:

(a) On 1 May 2001, PW1 visited Dr K Kunasegaran (PW3) at Sungai Petani Hospital. PW3 discovered two cysts in the plaintiff's ovaries.

(b) On 21 May 2001, the plaintiff consulted the second defendant at Gleneagles Medical Centre, the hospital, who made the decision to carry out operation to remove the two cysts.

(c) On 5 June 2001, the plaintiff was admitted into the hospital.

(d) On 6 June 2001, the plaintiff was operated on and she stayed in the hospital until 8 June 2001. The plaintiff stated that second defendant informed her that operation to remove the two cysts was successful.

(e) On 7 June 2001 ie the follow up consultation, the second defendant gave the first Zoladex injection to the plaintiff.

(f) On 5 July 2001, the second Zoladex injection was administered.

(g) The plaintiff however continued to suffer the pain from her ovaries.

(h) The plaintiff went to see Dr K Kunasegaran (PW3) at Sungai Petani Hospital and Dr K Kunasegaran asked her to obtain her medical report from the second defendant.

(i) On 23 July 2001, the plaintiff saw the second defendant who agreed albeit reluctantly and gave her medical report to her.

(j) On 24 July 2001, the plaintiff saw Dr K Kunasegaran with her medical report. Dr K Kunasegaran read the report and said that the cysts were not successfully removed. A scan was done. The plaintiff said Dr K Kunasegaran showed her two pictures of the scan of her cysts and told her that she had to undergo another operation to remove the two cysts. The plaintiff, however, intimated that she would try on traditional herbs.

(k) On 6 September 2001, the plaintiff went to Sungai Petani Hospital for appointment with Dr K Kunasegaran but was attended by Dr Maheran bt Rozali ('PW4') who is also an obstetrician and gynaecologist. PW4 did a scan and discovered two cysts were still there.

(l) On 24 June 2002, the plaintiff visited Dr Benny Khaw Soo Beng (PW2) at Tanjong Medical Centre Penang. Dr Benny Khaw confirmed the two cysts in the plaintiff's ovaries,

(m) On 8 July 2002, the plaintiff was operated by Dr Benny Khaw who had successfully removed the two cysts from her ovaries.

**[6]** In brief, what the plaintiff had narrated in evidence is that Dr K Kunasegaran (PW3) had diagnosed her with two cysts and the second defendant whom she consulted also confirmed the presence of the two cysts. The plaintiff opted to the second defendant instead of Dr K Kunasegaran to conduct the operation to remove her two cysts because she wished to make use of her medical insurance. After the operation by the second defendant, the

plaintiff continued to experience the same problem of pain and when she went back to Dr Kunasegaran, it was discovered that the operation conducted by the second defendant had failed to remove the two cysts in her ovaries. This result was allegedly from the scan performed by Dr Kunasegaran and it was also alleged that the subsequent scan done by Dr Maheran also confirmed the presence of the said two cysts. It is thus pertinent to look into the evidence of both Dr Kunasegaran (PW3) and Dr Maheran bt Rozali (PW4) whether two cysts still existed after the operation conducted on her by the second defendant.

**[7]** According to Dr Kunasegaran, he first saw the plaintiff on 12 December 1999 for secondary infertility and ultrasound showed cystic ovaries. He conducted laparoscopy on the plaintiff which showed bilateral ovarian endometriotic cysts and a bilateral cystectomy was done to remove the two cysts. On 15 May 2001 of about 1% years later, Dr Kunasegaran saw the plaintiff again and ultrasound showed probable recurrence of endometriosis, cystectomy was supposed to be carried out on 6 June 2001 but the plaintiff defaulted. On 24 July 2001, the plaintiff returned and informed him that she was operated in a private hospital. Dr Kunasegaran did an ultrasound scan on the plaintiff which showed an irregular cystic area in the plaintiff's pelvis measuring 4 x 3cm suspected of recurrent endometroma. When the plaintiff came back for a rescan on 6 September 2001 which was carried out by Dr Maheran, it showed a small cyst which Dr Kunasegaran ruled to be no significant findings.

**[8]** Dr Maheran (PW4) confirmed in her evidence that she attended to the plaintiff on 6 September 2001. Upon examination, she found the plaintiff to be well, not suffering from any pain and also not having her menstrual flow yet. During an ultrasound examination, PW4 noted that the plaintiff had a small cyst measuring about 2.5 x 2.6cm. In respect of this small cyst, Dr Kunasegaran who is the superior of Dr Maheran said in cross-examination that he could not say whether this 2.5.x 2.6cm in the diagram which was a cystic area could be a tumor or a collection of blood, fluid or inflamatory fluid. He stated in order to confirm endometriosis with cysts he had to perform a laparoscopy or open surgery but since the plaintiff had defaulted on 6 June 2001, laparoscopy was not carried out and hence he could not confirm whether the plaintiff had endometriosis cysts. He added that from his opinion, the lesion or irregular cystic area measuring 4 x 3cm from ultrasound done on 24 July 2001 which had shrunk to 2.5. x 2.6cm on 6 September 2001 of almost half the size, is unlikely to be endometroma.

**[9]** Dr Maheran indeed said further that she could not confirm conclusively whether the cyst she saw on 6 September 2001 was an old one or a recurrence. She added that the cyst was too small and that was why it was insignificant. In cross-examination, Dr Maheran said she could not say whether the cyst she saw

on 6 September 2001 was endometriotic cyst. She agreed that basing on the symptoms, it was unlikely to be endometriosis; however she could not confirm.

**[10]** Evidence of the second defendant showed that ultrasound examination carried out on the plaintiff suggested a cyst with echoes within in the right adnexa and a similar cyst in the left adnexa. As requested by the plaintiff, the second defendant performed laparoscopy, adhesiolysis and a dilatation and curettage on the plaintiff on 6 June 2001 but found no endometriotic cyst on both left and right ovaries. No chocolate fluid was drained upon aspiration of the cystic right ovary but fresh blood was obtained signifying no endometriotic cyst present. Laparoscopic ovarian cystectomy was therefore not required. DW3, Dato' Dr Alex Mathews who is a consultant obstetrician and gynaecologist at Gleneagles Intan Medical Centre, Kuala Lumpur and Vice President of the College of Obstetrician and Gynaecologists, Academy of Medicine Malaysia who has been practicing obstetrics and gynaecology for the past 31 years testified that an ultrasound examination is useful to determine the presence of endometriotic cysts but the findings are not always conclusive; a visual inspection of the pelvis by way of laparoscopy (an operation) is the gold standard investigation to confirm the presence of endometriosis. He opined that if fresh blood was drawn instead of chocolate fluid upon a aspiration of the plaintiff's cystic ovary, it means an endometriotic cyst is not likely to be present in the ovary. Dr Alex commented that although Dr Kunasegaran had stated that the ultrasound carried out on 4 July 2001 showed an irregular cystic area measuring 4 x 3cm suspicious of recurrent endometrioma, a repeat ultrasound carried out on 6 September 2001 by Dr Maheran showed no significant findings. The irregular cystic area seen by Dr Kunasegaran on ultrasound on 24 July 2001 could not, according to Dr Alex, have been an endometriotic cyst because an endometriotic cyst would certainly not have spontaneously cleared six weeks later by 6 September 2001 as noted from the repeat ultrasound carried out by Dr Maheran. He said the cyst noted by Dr Maheran measuring 2.5. x 2.6cm could have been a temporary collection of fluid after surgery, a collection of blood or even a follicle and it is unlikely to be a endometriotic cyst as endometriotic cyst could not have shrunk or reduced in size from 4 x 3cm as noted on ultrasound by Dr Kunasegaran on 24 July 2001 to 2.5 x 2.6cm from the ultrasound done by Dr Maheran on 6 September 2001.

**[11]** As to the two endometriotic cysts measuring 3.2 x 3cm and 3.9 x 3cm respectively removed by Dr Benny Khaw (PW2) on 8 July 2002 successfully of more than one year later, all specialist doctors PW2, PW3 and DW3 held the same view that new cyst can form within one or two months (from PW2) or six weeks after operation — size variable (from PW3) or within two to three months (from DW3).

**[12]** From all the evidence of the plaintiff and her witnesses above, what the plaintiff had alleged is that after the laparoscopy done by the second defendant on 6 June 2001, Dr Kunasegaran had on 24 July 2001 and Dr Maheran had on 6 September 2001 confirmed that the two cysts supposedly to have been operated and removed by the second defendant were still present signifying that the second defendant had negligently performed the laparoscopic ovarian cystectomy to remove the two cysts. However, evidence of Dr Kunasegaran showed otherwise that on 24 July 2001, from the ultrasound performed on the plaintiff, it showed only an irregular cystic area measuring 4 x 3cm and Dr Maheran noticed a small cyst measuring 2.5 x 2.6cm from an ultrasound done on the plaintiff on 6 September 2001 which was subsequently described by Dr Kunasegaran to be insignificant as he held the view that it is unlikely to be endometroma or endometriotic cyst for reason that the irregular cystic area that he saw on 24 July 2001 had shrunk to 2.5 x 2.6cm on 6 September 2001 of almost half the size. In other words, if it is endometriotic cyst, it could not have shrunk in size between 24 July 2001 to 6 September 2001 when there was no surgical intervention during this period. It is manifestly clear that the evidence of the plaintiff is totally contradicted by PW3 and PW4 who had never confirmed the presence of two cysts after the laparoscopy conducted by the second defendant. Dr Alex Mathew, DW3, shared the same view as Dr Kunasegaran. From the second defendant's clinical examination from the ultrasound images taken of the plaintiff (bundle H, p 2), there appeared two dark spots suspected of cysts. However, when laparoscopy was conducted on the plaintiff to ascertain the presence of cysts and to remove them, the second defendant could not visualise any cysts. Thus, if it is the contention of the plaintiff that the two cysts still remained in her ovaries and that the second defendant had been negligent in failing to remove them, the plaintiff must prove the presence or existence of the two cysts after her operation by the second defendant on 6 June 2001. However, there is no evidence from PW3 and PW4 of the presence or existence of the two cysts on 24 July 2001 and 6 September 2001. Even Dr Maheran's allegation of a small cyst was ruled out by Dr Kunasegaran to be an endometriotic cyst. The plaintiff has therefore failed to prove that from 6 June 2001 to 6 September 2001, she was still having the two endometriotic cysts which were supposedly to have been removed by the second defendant as alleged. The findings of Dr Kunasegaran who is also the Head of Department of Obstetric and Gynaecology, Sungai Petani Hospital and superior of Dr Maheran had ruled out the presence of endometriotic cysts in the ovaries and pelvis area of the plaintiff. These findings are consistent with the second defendant's result after laparoscopy carried out on 6 June 2001 that he could not see any cyst. The evidence of DW3 further confirmed the findings of Dr Kunasegaran and the second defendant that there was no cysts. The fact that Dr Benny Khaw had on 8 July 2002 removed two endometriotic cysts from the plaintiff cannot be the basis to contend that these two cysts were the same two cysts which the second defendant had failed to remove on 6 June 2001 for reasons that the laparoscopy ovarian cystectomy was performed by Dr

Benny Khaw more than one year after the second defendant had done the laparoscopy and that endometriotic cysts can recur even shortly after operation. Although the second defendant did not remove any cyst on 6 June 2001, it must be noted that the plaintiff had undergone an earlier bilateral cystectomy performed by Dr Kunasegaran to remove an endometriotic cyst in her left and another in her right ovary sometimes in December 1999. According to PW2, PW3 and DW3, all of whom are experts obstetricians and gynaecologist, the recurrence of endometriotic cysts seems common phenomena and can even occur within one to a few months after an operation; it is therefore not inevitable.

**[13]** From all the evidence before this court, I find that evidence of the plaintiff was not only uncorroborated by PW3 and PW4 of the presence or existence of the two endometriotic cysts but was directly contradicted by them, in particular by PW3. If cysts were present before and at the time of laparoscopy performed by the second defendant on 6 June 2001 and were not successfully removed, they ought to remain in the plaintiff's ovaries on 24 July 2001 and 6 September 2001 but they were not confirmed to be still there. The cystic area found on 24 July 2001 and the small cyst noted by Dr Maheran on 6 September 2001 were ruled out by Dr Kunasegaran to be endometriotic cysts. There was in fact no endometriotic cysts. The fact that the plaintiff was suffering from the symptoms was due to endometrosis which is a gynaecological condition that can occur with or without the formation of endometriotic cysts (see D34 Q & A 10). Consequently, I find that the plaintiff had failed to prove the presence or existence of the two endometriotic cysts before and at the time the second defendant performed the laparoscopy on her on 6 June 2001. The facts have clearly shown that there was no endometriotic cysts bearing in mind that the actual confirmation of the presence of endometriotic cysts is by laparoscopy and not by ultrasound scan. All the plaintiff's witnesses Dr Benny Khaw, Dr Kunasegaran and Dr Maheran endorsed that an ultrasound scan is not conclusive without a laparoscopy. Ultrasound was thus not conclusive proof to ascertain the presence or existence of cysts; ultrasound was only a probability and the plaintiff cannot base her case on mere ultrasound finding.

## SECOND ISSUE: WHETHER THE SECOND DEFENDANT WAS NEGLIGENT IN THE COURSE OF PERFORMING THE LAPAROSCOPY

**[14]** There is indeed no medical or expert evidence adduced by the plaintiff to prove the negligence of the second defendant in the conduct of the laparoscopy as pleaded. It appears that the plaintiff attempted to rely solely on her assumption from what she was told by Dr Kunasegaran and Dr Maheran that the two cysts which were supposedly to have been removed were still there

and hence the second defendant must be negligent in failing to remove them. However, bereft of any evidence, this court cannot even draw any inference as to any negligence on the second defendant in the conduct of laparoscopy on the plaintiff.

**[15]** Evidence of the second defendant ('DW2') showed that he had based his clinical finding of the two cysts deriving from the images of the ultrasound scan vide bundle H page 2 (the original print was shown to court and counsel during trial). The plaintiff consented to having laparoscopy varian cystectomy and it was performed on 6 June 2001 but no obvious endometriotic cyst was seen. Aspiration of the cystic left ovary were attempted but only blood was obtained and there was no chocolate fluid to signify the presence of cyst.

**[16]** The plaintiff's doctors PW2, PW3 and PW4 did not adduce any evidence to allege that by performing laparoscopy, there is a lack or breach of duty of care by the second defendant to the plaintiff. Evidence of Dr Alex Mathews ('DW3') when being referred the ultrasound images in bundle H, p 2 held the same view as the second defendant that there is possibility of one cyst at the right and one at the left ovary basingon the plaintiff's history of having pain at that part of her anatomy. This is the descriptive aspect of these images. From the interpretative aspect of these images, the suspected cysts could be functional cysts or a large blood vessel seen in crosssection; it could also be a collection of fluid that surrounds the ovary but not inside the ovary that can sometimes take place after earlier surgery in the pelvis. Dr Alex also opined that it will rightly benefit the plaintiff to have a procedure to remove the endometriotic cyst if there is a cyst. Dr Alex as well as Dr Kunasegaran agree that laparoscopy is the procedure which will confirm affirmatively the presence of endometriotic cysts. Since the second defendant could not visualise any cyst through laparoscopy and had made the clinical judgment that open surgery might pose risk to the plaintiff in view of the dense adhesions at the pelvis of the plaintiff he did not perform the cystectomy nor the open surgery. From the findings on laparoscopy, the second defendant had informed the plaintiff that laparoscopic ovarian cystectomy would not be required. Dr Alex Mathews testified that the second defendant had accorded the plaintiff appropriate management and treatment.

**[17]** There is no doubt that there is a duty of care owed by a doctor to his patient; without this doctor patient relationship, there is no duty on the doctor to diagnose, advise and treat his patient; see *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593 (FC). With the special skill and knowledge, the doctor owes a duty to the patient to use his skill, knowledge, diligence and care in administering the treatment. However, I find no evidence that the second defendant has breached his duty of care to the plaintiff in the management and treatment of the plaintiff or that second defendant had been negligent in the

conduct of laparoscopy which is to ascertain the presence of endometriotic cysts before the laparoscopic ovarian cystectomy could be performed to remove them, I also do not find the second defendant to have breached his duty of care when he declined to carry out open surgery as he had balanced the risk and benefit of such open surgery to the plaintiff. Dr Alex also endorsed the fact that there are major blood tissues linked to major organs at the pelvis which is dangerous to operate. In fact, as subsequently confirmed by Dr Kunasegaran, there was no endometriotic cysts. Hence the decision of the second defendant was right that he did not continue to perform cystectomy or open surgery for probing purposes which might endanger the plaintiff. He had exercised due diligence, care, skill and knowledge in circumstances where the danger to the patient's safety outweighed the necessity to perform an investigatory operation. On a positive finding of facts, I do not find the second defendant to be negligent in the conduct of the laparoscopy in this case.

## THIRD ISSUE: IS IT WRONGFUL FOR THE SECOND DEFENDANT TO ADMINISTER TWO Zoladex INJECTIONS ON THE PLAINTIFF AFTER LAPAROSCOPY

**[18]** According to the second defendant, after the laparoscopy, he had discussed with the plaintiff whether the plaintiff would consider having Zoladex because of the plaintiff's history of endometriosis which she continued to suffer. Zoladex injections are accepted form of treatment for patients suffering from endometriosis whether with or without endometritic cysts. The second defendant said the plaintiff agreed and the second defendant then administered the first injection on 7 June 2001. The plaintiff complained that the injection was painful and did not wish to have a further injection during her follow up consultation on 5 July 2001. However, she changed her mind on 5 July 2002 and hence the second Zoladex injection was administered.

**[19]** From the second defendant's evidence, it indirectly shows that the administering of Zoladex injections on the plaintiff was after consultation with the plaintiff and it was administered with her full consent. The question is whether Zoladex injection is beneficial to the plaintiff in the treatment of the plaintiff's endometriosis. If it is not, such administering could be construed as wrongful; otherwise, it will not be. Evidence of Dr Benny Khaw (PW2) established a fact that he too gave six courses of Zoladex injections to the plaintiff to be administered one per month after her laparoscopic bilateral cystectomy performed by him. PW2 stated in examination-in-chief in his oral evidence in court that after an operation, a patient is required to have Zoladex injection to prevent recurrence. Even without an operation, patient could have Zoladex injection as an alternative treatment. Dr Kunasegaran (PW3) also expressed that Zoladex injections can be beneficial to patient with endometriosis. Though there is side effect, it is not harmful and can help to

treat the patient. Generally, according to PW3, Zoladex would not be prescribed if obstetricians and gynaecologists do not suspect endometriosis but Zoladex will benefit patient with endometriosis. PW4, Dr Maheran similarly endorsed the advantages in the prescription of Zoladex. She said she would still prescribe Zoladex even though her operation on the patient was successful, in situation where it was highly unlikely to see the endometriotic spots when laparoscopy was done, Zoladex would be administered. Dr Alex Mathews (DW3) also expressed the view that the Zoladex injections administered by the second defendant to the plaintiff are beneficial to treat the plaintiff's long standing endometriosis even though there were no endometriotic cyst present in the plaintiff's ovaries.

**[20]** From the evidence of all the obstetricians and gynaecologists, PW2, PW3, PW4 and DW3, there is no doubt that Zoladex injections are the recognised and accepted medication for the treatment of endometriosis. The plaintiff has had a history of endometriosis and her complaints indicated the recurrence of endometriosis. According to PW4, Dr Maheran, there is no cure for endometriosis except to make the patient menopause. For the second defendant to prescribe and administer Zoladex injections on the plaintiff, it cannot be said to be wrongful since this is the recognised and accepted prescription for endometriosis which the plaintiff had the history and her symptoms as complained indicated recurrence of endometriosis even though the second defendant did not see the endometriotic cysts from the laparoscopy done. I find that what the second defendant had administered on the plaintiff of Zoladex was the recognised beneficial medication for the plaintiff who suffered from the similar symptoms of endometriosis. I do not find in the circumstances that the second defendant had acted wrongfully in administering Zoladex injections on the plaintiff. After all, it was also with her consent.

FOURTH ISSUE: IS THE FIRST DEFENDANT VICARIOUSLY LIABLE FOR THE ACT OF THE SECOND DEFENDANT

**[21]** This issue is only relevant if the second defendant is found to be liable to the plaintiff on professional negligence and wrongful administering of Zoladex injections. Nevertheless, for completeness, evidence and submissions by all parties are considered. From exh D18 which is the agreement between the first defendant and Kaysibeng Sdn Bhd, the second defendant's company, the second defendant was allowed to practice as an independent and freelance consultant and gynaecologist at the hospital. The first defendant submitted that there is no employer-employee relationship between the first and second defendants; the second defendant has clients of his own, operates his own clinic at the hospital but was the operating facilities of the hospital which he has to pay a percentage of his charges on his clients; the second defendant also had full

control over the treatment, management and care of the plaintiff as well as the amount of fees charged. Hence, the first defendant submitted that they are not liable for the act of the second defendant. The plaintiff contended that vide the said agreement D18, the first defendant is taking 22.5% of the gross fees earned by the second defendant as consideration vide cl 5 and by cl 6, the first defendant grants the second defendant 30 days vacation leave. The plaintiff submitted that these two clauses connote an employer-employee relationship. In *Tan Eng Siew & Anor v Dr Jagjit Singh Sidhu & Anor* [2006] 1 MLJ 57 as cited by learned counsel for the first defendant, His Lordship James Foong J (now FCJ) has well summarised the tests applicable in determining whether there is special relationship between the defendants to constitute vicarious liability when His Lordship said at p 69:

> [35] To ascertain whether such special relationship exists, the courts have devised various tests. The first is the control test as laid down in *Short v J & W Henderson Ltd* (1946) 62 TLR 427 at p 429. Here the criteria are: first, the power of selection of the employer; second, power in determining salary or other remuneration; third, power or right of the employer to control the method in which the work was done; fourth, power and right of the employer to terminate the employee's services.
>
> [36] Then there is the organisational tests. This is laid down in *Stevenson, Jordan & Harrison Ltd v MacDonald & Evans* [1952] 1 TLR 101 at p 111. Here the court examines the wrongdoer's work in relation to organisation set up by the party who is alleged to be vicariously liable for his action.
>
> [37] Finally, there seem to be a third test known as the multiple test adopted by the courts as shown in *Ready Mixed Concrete (South East) Ltd v Minister of Pensions and National Insurance* [1968] 2 QB 497 which is said to be based on the common sense approach.
>
> [38] All in all, what that is necessary for the second plaintiff to establish in this case against the second defendant is that whether the second defendant has a control over the first defendant to create a form of special relationship that can cause the second defendant to be vicariously liable for the wrongdoing of the first defendant, if proven.

**[22]** Having perused the whole agreement D18 as well as the evidence produced and applying the tests as laid down above, I am inclined to agree with the submission by the first defendant that there is an absence of such special relationship between the first defendant and the second defendant on the following grounds:

(a) The second defendant is free to operate his own clinic, accepting whosoever patients he wants and the second defendant is at liberty to charge a different fee from the patient despite there is a schedule of fees.

(b) The second defendant has full control over his own clients/patients in their treatment, management and care. He controls over his own work and the method he wishes to perform his work.

(c) The first defendant does not pay any remuneration to the second defendant but conversely, the second defendant would have to allow 22.5% of his gross fees earned to be deducted towards usage of the first defendant's facilities (cl 5, D18). Bearing in mind that the first defendant is providing all the facilities of a hospital to the second defendant, the deduction of 22.5% of the gross fees earned by the second defendant can only be construed as payment by the second defendant for such usage of those facilities only. I do not agree with the plaintiff's contention that such payment connotes a special relationship of an employer-employee.

(d) The second defendant will have to immediately take out insurance coverage and shall maintain such policies to keep himself insured at all times during the subsistence of the agreement with the first defendant (cl 7(f), D18). If there is such an employer-employee relationship as contended by the plaintiff, insurance coverage of an employee would be generally provided by employer if the employee is not covered under SOCSO.

(e) On cl 6 which provides that the first defendant shall allow the second defendant 30 days leave in every calendar year, the plaintiff contended this shows the special relationship of employer-employee. Reading the second paragraph that follows in cl 6, which requires the second defendant to arrange and secure the services of a consultant colleague to provide cover during any period of leave, it corroborated evidence of the first defendant that there should be no vacancy of any consultant in attendance as the hospital must have a consultant at all times. If there is employer-employee relationship as contended by the plaintiff, when the employer who retains his full discretion to approve vacation leave and once the leave of the employee is approved, it becomes the duty of the employer to arrange for a replacement worker and not the duty of the employee to find such a replacement before he goes on his vacation leave.

(f) The negligent act and wrongful act complained of by the plaintiff are in relation to the personal acts of the second defendant in the treatment, management and care of the plaintiff which the second defendant retains full control. Therefore, the first defendant cannot be said to be vicariously liable.

**[23]** Consequently, I do not find, that vicarious liability can be attributed to the first defendant.

## CONCLUSION

**[24]** For the foregoing reasons and upon a finding of facts, I hold that the plaintiff had failed to prove her claim on a balance of probabilities. Therefore, the plaintiff's claim is dismissed with costs of RM10,000 to each defendant.

*Plaintiff's claim dismissed with costs.*

Reported by Kanesh Sundrum